VSH FUTURES
Care Management Work Group
DRAFT Meeting Minutes
January 13, 2006

Meeting Participants
Stuart Graves, WCMH/NKHS; Michael Sabourin, NKHS, VPS, VP&A; Jeff Rothenberg, CMC; Nick Emlen, VT Council; Bob Jimmerson, CSAC; Tom Simpatico, VSH/UVM/FAHC; Bill McMains, DMH; Cathy Rousse, NKHS; Bob Pierattini, FAHC/UVM; Peter Tomashow, CVH; Michael Hartman, WCMH; Cindy Thomas, DMH; Patti Barlow, DMH; Rich Lanza, LCMHS; Fritz Engstrom, B. Retreat; Gregory Miller, B. Retreat; Sandy Steingard, HCHS; Rep. Anne Donahue, VPS.

Staff
Beth Tanzman, DMH

INTRODUCTION
Chair Bob Pierattini suggested that the group stay together for today's meeting to allow sufficient time for reports and discussions on the sub group tasks. He requested that group members focus on addressing two questions:

- What work products are ready to take before the full Futures Advisory Committee at the January 23 meeting?
- What are the next steps for the subgroups?

REPORT FROM THE LEVEL-OF-CARE WORK GROUP chaired by Tom Simpatico. Tom summarized the efforts of the work group to date. The group has been focusing on defining the sub acute rehabilitation level of care and therefore has significant overlap with the sub acute / secure residential work group. Tom offered that the first conception of the sub acute level of care was as a replacement for the current VSH Brooks Rehab unit. As the programs develop, the original idea is evolving. As sub group chair, Tom felt that his key role has been to identify specific program elements that require active decisions in order to define the level of care. These are:

- What capability will sub acute programs have to carry out *emergency* involuntary procedures?
- What psychiatric coverage will be available?
- What specific treatment modalities will these programs provide?
- Will these programs be able to continue use of *non-emergency* involuntary medications begun at VSH?
- What will be the legal status of residents of the sub-acute programs?
- Generally, where will these programs fall on the voluntary - involuntary continuum?
- How will residents return to the hospital if that is needed?

Tom passed out a draft summary "Care Management System: System Description Sub Committee (01/13/06)." This document lays out the roles and functions of the Vermont State Hospital, the Designated Hospitals, the Sub Acute Rehabilitation Programs, Secure

Residential Programs, and one type of HUD- Funded housing program - ShelterPlus Care. This document attempts to summarize the work group discussions to date.

Meeting participants reviewed the sub-acute rehabilitation section and the following are discussion highlights. First members discussed the issue of providing emergency involuntary interventions.

Sub Acute and Emergency Involuntary Interventions

As currently proposed the levels of care work group offers the following:

a) Sub acute rehabilitation units are 24-hr residential units, community-based, intended to assist persons to transition out of more restrictive treatment settings, ie. VSH.
b) They are intended to provide voluntary treatment.
c) Able to take patients under an order of non-hospitalization (ONH).
d) There would be the capacity to handle agitated patients by virtue of providing one-to-one or possibly two-to-one staff monitoring as well as affording time in a quiet room.
e) Short term manual restraint would be available, but mechanical restraints and emergency involuntary medications would not be available.
f) Containment would largely be provided by staff surveillance, although exterior doors would have the capacity to lock if deemed clinically necessary.
g) Sub acute rehab units would ideally be designated through ACT 114 so that persons would continue to take court-ordered non-emergency oral involuntary medications.
h) The covering psychiatrist could be present in the program within one-hour of notification.

In response to a question, Tom shared that the subgroup's thinking around only very limited use of emergency involuntary interventions was due to staffing availability (only three staff on at a time - and most think it takes at least five staff to safely restrain a person), response time for psychiatry (one hour is too long to meet CON standards), and the desire to limit coercion in the system. Participants questioned the wisdom of creating such programs without the staff training and the capability to safely do emergency interventions. Tom offered that the program developers say they will have no capability to do mechanical restraints, and that they staff an agitated individual as best they can and wait for the police to arrive. Group members questioned whether using the police to remove an agitated person from a sub-acute program to the hospital or jail would be "less restrictive" than an emergency involuntary medication that may allow the person to remain in the program?

Some participants suggested that we should build in the training and capability to use emergency involuntary interventions, not as a typical course of treatment, but so that the sub-acute programs could accept a patient who, for example, required seclusion once in the previous month. The issue is, if there is too little capacity for emergency intervention, would this essentially 'ham-string" the staff, requiring the more hardened intervention of the police?

On the other hand, the current Brooks Rehab unit does not do seclusion or restraints, so why would the sub-acute programs need emergency procedures? As a practical matter, it

is easy to move a patient from the Brooks Rehab unit to another unit if they require emergency interventions. This would be much harder to effect in a rurally located sub-acute program. The limited emergency intervention capability of the sub-acute programs may narrow the range of eligible VSH patients for this program level. This view was countered with the observation that the core safety or security issues for the Brooks Rehab population are motivation and preventing people from wandering off. This group of patients is generally not assaultive and they are not non-collaborative; they are more a-collaborative. Therefore, the question of emergency involuntary intervention capability is essentially the wrong frame to use to define the sub acute programs and their capabilities.

There was general concurrence that the currently proposed staffing plan (3 staff on) is not adequate to safely physically restrain an individual. However, there was interest expressed, given the nursing staffing, in exploring whether more could be done with emergency medications. Specifically, Beth will research what the federal residential program requirements are for emergency medication. Up till now the work group has been assuming that the hospital-level rules are in play.

Sub Acute and the Issues of Rapid Return to Hospitalization

Work group discussions to date continue to struggle with the limitations of the ONH revocation process. It is simply not timely enough (currently months) to be a useful tool to effect a rapid return of a person to inpatient care. In addition, the MH Law Project has clearly communicated that "stipulated EE arrangements" as part of ONH agreements will only be recommended in unusual circumstances. The Sub-Acute /Secure Residential Work group will have Lee Susskin (court administrator), Wendy Beinner, AG Office, and Jack McCoullough at the next meeting (February 1st 9-11, Tom Simpatico's VSH office) to discuss options for more timely access to the court docket. The CRT directors would very much like to see an agreement to hold ONH revocation hearings within two weeks. The MH Law Project's position is reported to be that they cannot provide adequate representation to clients in a two week timeframe with their current resources. The CRT council would like to see all ONH revocations hearable within two weeks and would propose to resource Legal Aide to meet this timeframe.

Sub Acute and Act 114

The proposal to designate sub-acute programs for Act 114 was discussed. Tom stated that the work group members had not envisioned starting new non-emergency involuntary medication orders from the sub-acute programs; rather, they could continue orders established during a course of hospitalization. Other meeting participants questioned whether Act 114 was necessary to implement sub-acute programs, noting that it is a "lightening rod" for controversy. This will require much more discussion, including with the full Futures Advisory Committee.

Is Sub Acute Truly a New Level of Care and Can it Reduce VSH by 16 Beds?

Members questioned if the proposed sub-acute level of care was really different from existing levels of care. The group divided on this question, with some saying that the much "beefier" staffing pattern, nursing coverage and psychiatry involvement constitutes

a new level of care. Others felt that it is not different enough from existing residential programs to really downsize VSH by the promised 16 beds. Members suggested that the census reduction goal be tested using the newly developed sub-acute program description on the current VSH population. If the sub-acute programs are voluntary, cannot do seclusion or restraint, and cannot apply Act 114 -- does this really reduce the VSH population by 16 beds, ongoing? Maybe. Who do we (community providers) know at VSH now who could use this type of program? With the significant caveat that the clients must be willing to try the program, the sub acute program as proposed could significantly impact on the VSH census.

Discussion Conclusions

- The overall preference of the care management work group and the sub acute rehabilitation work group is to define the sub-acute level of care as voluntary.
- It will be difficult to definitively state whether or not this level of care, so defined, will reduce the VSH census by 16 at any given time until the programs are up and running. Therefore, the political commitment to absolute census reduction must be softened and the administration and legislators alerted to this.
- The question of Act 114 requires further discussion. This would be assisted by a description of what it would be procedurally involved in implementing Act 114 in a community setting.
- Collaborating with the MH Law Project and the Court Administrator, the work group will actively pursue much more timely hearings for ONH revocations.

REPORT FROM THE CLIENT MOVEMENT WORK GROUP: chaired by Nick Emlen. Nick reviewed that the group has drafted a series of principles to guide client movement throughout the services system. Based on feedback, he will be integrating a fourth draft of the principles. This fourth draft will be ready for the full VSH Futures Advisory Committee's consideration at the January 23 meeting. Nick also reviewed the seven initial protocols designed to implement the principles that are under development. These are:

- Crisis / emergency screening
- Admission criteria
- Census management
- Safety need determination
- Transportation
- System-wide discharge planning for persons not connected to community services
- Payment for services for people without a payor source

The care management meeting participants suggested two additional protocols for development:
1) Conflict Resolution
2) Client Rights

Nick will collect and distribute the draft protocols developed to date.

NEXT STEPS

1) The levels-of-care work group will move on to defining other levels of care (inpatient, specialized inpatient, and ICU).
2) The client movement through the system group will continue protocol development work.
3) The Sub Acute / Secure Residential work group is requested to test the model against the current VSH population.
4) The proposal to implement Act 114 in the sub acute programs needs more discussion and procedural clarification.
5) The commitment to census reduction vis a vis sub acute programs needs to be softened.

Finally, the work group emphasized that it is CRITICALLY IMPORTANT TO MAINTAIN THE BED AND STAFFING CAPACITY AT VSH WHILE THE NEW PROGRAMS ARE DEVELOPED.

The meeting adjourned at 11:05.

Next meetings (location Central VT Hospital, Berlin):

February 17th, 9:00 - 11:00
March 17th, 9:00 - 11:00